CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS

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A participating provider is an independent laboratory that has a current signed participation agreement with the Department of Medical Assistance Services, is licensed and certified by the appropriate licensing agency, and meets Medicare-Medicaid participation requirements.

PROVIDER ENROLLMENT

Any provider of services must be enrolled and have a current participation agreement with the Virginia Medicaid Program prior to billing for any services provided to Medicaid recipients. (See the "Exhibits Section" at the end of this chapter for a sample provider agreement.) All providers must sign the appropriate Participation Agreement and return it to the Provider Enrollment and Certification Unit; an original signature of the individual provider is required. Continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of the provider license. Failure to renew the license through the licensing authority shall result in the termination of the Medicaid Participation Agreement. All participants are required to complete new agreement forms when a change of ownership occurs.

Upon receipt of the above information, a provider number is assigned to each approved provider. This number must be used on all claims and correspondence submitted to Medicaid and may not be used by another provider.

This manual contains instructions for billing and specific details concerning the Medicaid Program. Please read the entire manual before billing Medicaid. Providers must comply with all sections of this manual to maintain continuous participation in the Medicaid Program.

REQUESTS FOR PARTICIPATION

In order to become a Medicaid provider of services, the provider must request a participation agreement by writing, telephoning, or faxing their request to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-5105 or 1-888-829-5373 (in state toll-free), fax - 804-270-7027

PARTICIPATION REQUIREMENTS

Providers approved for participation in the Virginia Medicaid Program must perform the

following activities as well as any other specified by DMAS:

- Immediately notify the Department of Medical Assistance Services, in writing, of any change in the information which the provider previously submitted to the Department.

- Ensure freedom of choice to recipients seeking medical care from any other provider qualified to perform the needed service(s) and participating in the Medicaid Program at the time the service was performed.

- Assure the recipient's freedom to reject medical care and treatment.

- Provide services and supplies to recipients in full compliance with Title VI of the Civil Rights Act of 1964 which prohibits discrimination on the grounds of race, color, religion, or national origin.

- Provide services and supplies to recipients in full compliance with the requirements of the Rehabilitation Act of 1973 requiring that all necessary accommodations be made to meet the needs of persons with semi-ambulatory disabilities, sight and hearing disabilities, and disabilities of coordination (refer to section regarding the Rehabilitation Act on page five of this chapter).

- Provide services and supplies to recipients in the same quality and mode of delivery as provided to the general public.

- Charge the Department of Medical Assistance Services for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public.

- Accept as payment in full the amount reimbursed by the Department of Medical Assistance Services. The Code of Federal Regulations, 42 CFR, Section 447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency." A provider may not bill a recipient for a covered service regardless of whether the provider received payment from the State providing the recipient was Medicaid eligible at the time service was rendered. A provider may not seek to collect from a Medicaid recipient, or any financially responsible relative or representative of that recipient, any amount that exceeds the established Medicaid allowance for the service rendered. For example: If a third party payer reimburses $5.00 out of an $8.00 charge, and Medicaid's allowance is $5.00, then payment in full of the Medicaid allowance has been made. The provider may not attempt to collect the $3.00 difference from Medicaid, the recipient, a spouse, or a responsible relative.

- Accept assignment of Medicare benefits for eligible Medicaid recipients.

- Use Program-designated billing forms for submission of charges.

- Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided.

  Such records must be retained for a period of five years from the date of service or as provided by applicable state laws, whichever period is longer. If an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved. (Refer to section regarding documentation of records on page four of this chapter.)

- Furnish to authorized State and federal personnel, in the form and manner requested, access to records and facilities.

- Disclose, as requested by the Department of Medical Assistance Services, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to recipients of medical assistance.

- Hold information regarding recipients confidential. A provider shall disclose information in his possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of the state agency. The state agency shall not disclose individual recipient medical information to the public.

PARTICIPATION CONDITIONS

All providers enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their individual provider agreements.

CERTIFICATION AND RECERTIFICATION

The Virginia Medicaid Program depends upon the participation and cooperation of physicians who provide or order health care services. The physician is responsible for certifying that the service is medically necessary and that the treatment prescribed is in accordance with community standards of medical practice.

Physicians, General

Medicaid recognizes the physician as the key figure in determining utilization of health services. The physician decides upon admission to a hospital; orders tests, drugs, and treatments; and determines the length of stay. The Program calls for substantiation of certain physician decisions as an element of proper administration and fiscal control. Payment for certain covered services may be made to a provider of services only if there is a physician's certification concerning the necessity of the services furnished, and, in certain instances, only if there is a physician's recertification for the continued need for the covered services.

MEDICAID PROGRAM INFORMATION

A provider having access to DMAS publications as part of a group practice may not wish to receive a provider manual and Medicaid Memos. To suppress the receipt of provider manuals and Medicaid Memos, complete the Program Information form (see the copy in the "Exhibits Section" at the end of this chapter.) and return it to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-5105 or 1-888-829-5373 (in state toll-free), fax - 804-270-7027

Upon receipt, DMAS will process the completed form and the provider named on the form will no longer receive publications from Virginia Medicaid. To resume the mailings, the provider must submit a written request sent to the same address.

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 provides that no handicapped individual shall, solely by reason of the handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, all Medicaid providers have the responsibility for making provision for handicapped individuals in their program activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring the compliance of individual providers. A compliance notice is printed on the back of checks issued to providers, and, by endorsement, the provider indicates compliance with Section 504 of the Rehabilitation Act.

In the event a discrimination complaint is lodged, DMAS is required to provide the Office of Civil Rights (OCR) with any evidence regarding compliance with these requirements.

DOCUMENTATION OF RECORDS

All laboratory tests billed to the Program must have documented results. Those laboratory tests listed as quantitative tests by the CPT must be documented by a numerical result. Qualitative tests are to be documented by positive or negative. Those laboratory services requiring descriptive results are to be fully documented.

Documentation examples are listed below:

Quantitative tests:
WBC - 7,000/mm^3
Glucose - 85 mg/100ml

Qualitative tests:
Monoscreen - positive
Pregnancy test - negative

Descriptive tests:
Urine microscopic - clear, yellow-brown, few wbc, rare renal epithelial cell
Urine culture - greater than 10^5/ml E. coli

The record must identify the patient on each page.

TERMINATION OF PROVIDER PARTICIPATION

The participation agreement is not time-limited, and will only expire upon the lapse or loss of licensure or certification of the provider, action taken by DMAS to meet the requirements of the agreement, regulations or law, inactive participation by the provider (no billing within 36 months), or resignation by the provider. DMAS will request a copy of the renewed licensure/certification prior to its expiration.

A participating provider may terminate participation in Medicaid at any time. Thirty (30) days' written notification of voluntary termination should be made to the Director, Department of Medical Assistance Services and First Health Provider Enrollment Unit.

DMAS may terminate a provider from participation upon thirty (30) days' written notification. Such action precludes further payment by DMAS for services provided recipients subsequent to the date specified in the termination notice.

The Code of Virginia, Chapter 10, Department of Medical Assistance Services, Section 32.1-325(c), mandates that "Any such (Medicaid) agreement or contract shall terminate upon conviction of the provider of a felony."

RECONSIDERATION AND APPEALS OF ADVERSE ACTIONS

The following procedures will be available to all providers when DMAS takes adverse action which includes termination or suspension of the provider agreement.

The reconsideration and appeals process will consist of three phases: a written response and reconsideration to the preliminary findings, the informal conference, and the formal evidentiary hearing. The provider will have 30 days to submit information for written reconsideration and will have 30 days' notice to request the informal conference and/or the formal evidentiary hearing.

An appeal of adverse actions concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (Section 2-2-4000 et seq.) and the State Plan for Medical Assistance provided for in Section 32.1-325 of the Code of Virginia. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the Administrative Process Act.

Any legal representative of a provider must be duly licensed to practice in the Commonwealth of Virginia.

REPAYMENT OF IDENTIFIED OVERPAYMENTS

Pursuant to Section 32.1-325.1 of the Code of Virginia, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When a lump sum cash payment is not made, interest will be added on the declining balance at the statutory rate pursuant to the Code of Virginia, Section 32.1-313.1. Repayment and interest will not apply pending appeal. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates to the satisfaction of DMAS a financial hardship warranting extended repayment terms.

EXHIBITS

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COMMONWEALTH OF VIRGINIA
Department of Medical Assistance Services
Medical Assistance Program

Independent Laboratory Participation Agreement

If re-enrolling, enter Medicaid Provider Number here→ _____ Check this box if requesting new number→ ☐

This is to certify:

	PAYMENT/CORRESPONDENCE ADDRESS	**PHYSICAL ADDRESS (*REQUIRED IF DIFFERENT FROM PAYMENT ADDRESS*)**
NAME		
ATTENTION		
ADDR LINE 1		
ADDR LINE 2		
CITY, STATE, ZIP		

on this _____ day of _____, _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

1. **This laboratory is certified to participate under Title XVIII of Public Law 89-97 and/or this laboratory meets the condition for Coverage of Services for Independent Laboratories governing participation under Title XVIII, Public Law 89-97.**
2. **Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. No handicapped individual shall, solely by reason of his handicap be excluded from participation in, be denied the benefits of, or be subjected to discrimination in (Section 504 of the Rehabilitation Act of 1973 29 §USC 794) VMAP.**
3. **Services rendered must be those provided. Payment is to be made only to those providers who actually render the service.**
4. **The applicant agrees to keep such records as VMAP determines necessary. The applicant will furnish VMAP on request information regarding payments claimed for providing services under the state plan. Access to records and facilities by authorized VMAP representatives, the Attorney General or his authorized representatives, and federal personnel will be permitted under reasonable request.**
5. **The applicant agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests for payment will comply in all respects with the policies of VMAP for the submission of claims.**
6. **Payment by VMAP constitutes full payment except for patient pay amounts determined by VMAP, and the applicant agrees not to submit additional charges to the recipient for services covered by VMAP.**
7. **The applicant agrees to pursue all other third party payment sources prior to submitting a claim to VMAP.**
8. **Payment by VMAP at its established rates for the services involved shall constitute full payment to the provider. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider will reimburse VMAP upon demand.**
9. **The applicant agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended.**
10. **This agreement may be terminated at will on thirty days' written notice by either party or by VMAP when the applicant is no longer eligible to participate in the Program.**
11. **All disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.**

12. **This agreement shall commence on _____. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement.**

For First Health's use *only*

Director, Division of Program Operations Date

IRS Name (required)

mail one completed **original** agreement to: **First Health - VMAP-Provider Enrollment Unit, PO Box 26803, Richmond, Virginia 23261-6803**

For Provider of Services:

Original Signature of Provider **Date**

_____City *OR* _____County of

IRS Identification Number **(Area Code) Telephone Number**

CLIA Number **UPIN**

Medicare Carrier and Vendor Number

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

MAILING SUSPENSION REQUEST

Medicaid Provider Number: _____

Provider Name: _____

I do not wish to receive Medicaid memos, forms or manual updates under the Medicaid provider number given above because the information is available to me under Medicaid provider number

Provider Signature: _____

Date: _____

Please return this completed form to:

First Health Provider Enrollment Unit
P.O. Box 26803
Richmond, VA 23261-6803